VERIFICATION OF CURRENT SUPERVISING PHYSICIAN

PLEASE COMPLETE THIS SECTION OF THE FORM AND MAIL TO YOUR CURRENT SUPERVISING PHYSICIAN.

DEAR CURRENT SUPERVISING PHYSICIAN:
In applying for a license to practice athletic training in South Dakota, the Medical Board requires this form to be completed by my **CURRENT** supervising physician. This is your authority to release any information in your files, favorable or otherwise, direct to:

South Dakota State Board of
Medical & Osteopathic Examiners
125 S. Main Ave.
Sioux Falls, SD 57104

_____
(Signature)

Name: _____
Address: _____
_____

DO NOT DETACH

Name of Current Supervising Physician: _____

Name of Employee: _____

Was employee's employment terminated? _____ (Yes or No)

If YES, Why? _____

_____

Derogatory Information, if any _____

_____

Comments, if any _____

_____

Signed: _____
Supervising Physician

Title: _____

Date: _____